		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0041467

Facility Name: Lynncrest Manor of Aledo

Address: 304 S.W. 12th Street (Number) Aledo (City) 61231 (Zip Code)

County: Mercer

Telephone Number: (309) 582-5376 **Fax #** (309) 582-2435

IDPA ID Number: 371346156001

Date of Initial License for Current Owners: 04/01/96

Type of Ownership:

	VOLUNTARY,NON-PROFIT	x	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		x	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Michael Kaplan **Telephone Number:** 312-634-4582
Altschuler, Melvoin & Glasser LLP
One South Wacker Drive
Chicago, IL 60606-3392
Please send copies of any desk review or audit adjustments to the above address.

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) _____
(Firm Name & Address) Altschuler, Melvoin & Glasser LLP, One South Wacker Drive, Chicago, Il 60606-3392
(Telephone) (312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lynncrest Manor of Aledo # 0041467 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds n/a

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	100	Skilled (SNF)	100	36,600	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	100	TOTALS	100	36,600	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			1,249	1,249	8
9	SNF/PED					9
10	ICF	18,911	7,719		26,630	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,911	7,719	1,249	27,879	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.17%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [x] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

I. On what date did you start providing long term care at this location?
Date started 04/01/96

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 02/01/98 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 12 and days of care provided 1,249

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lynncrest Manor of Aledo # 0041467 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7 **	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	115,464	13,284	13,774	142,522		142,522		142,522			1
2	Food Purchase		138,022		138,022		138,022	(3,111)	134,911			2
3	Housekeeping	68,557	7,515	68	76,140		76,140		76,140			3
4	Laundry	22,410	18,389	1,720	42,519		42,519		42,519			4
5	Heat and Other Utilities			67,871	67,871		67,871	154	68,025			5
6	Maintenance	20,295	267	50,792	71,354		71,354	199	71,553			6
7	Other (specify):*											7
8	**TOTAL General Services**	226,726	177,477	134,225	538,428		538,428	(2,758)	535,670			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	960,947	47,582	95,110	1,103,639		1,103,639		1,103,639			10
10a	Therapy			116,597	116,597		116,597		116,597			10a
11	Activities	34,394	7,478	5,252	47,124		47,124		47,124			11
12	Social Services	20,172	645	2,293	23,110		23,110		23,110			12
13	Nurse Aide Training	7,906		5,756	13,662		13,662		13,662			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,023,419	55,705	231,008	1,310,132		1,310,132		1,310,132			16
	C. General Administration											
17	Administrative	65,298		46,678	111,976		111,976	(46,678)	65,298			17
18	Directors Fees											18
19	Professional Services			31,569	31,569		31,569	2,499	34,068			19
20	Dues, Fees, Subscriptions & Promotions			9,663	9,663		9,663	(170)	9,493			20
21	Clerical & General Office Expenses	83,786	43,352	20,943	148,081		148,081	3,385	151,466			21
22	Employee Benefits & Payroll Taxes			176,696	176,696		176,696	4,189	180,885			22
23	Inservice Training & Education			237	237		237	1,384	1,621			23
24	Travel and Seminar			7,268	7,268		7,268	934	8,202			24
25	Other Admin. Staff Transportation			2,948	2,948		2,948		2,948			25
26	Insurance-Prop.Liab.Malpractice			36,556	36,556		36,556	50	36,606			26
27	Other (specify):*											27
28	**TOTAL General Administration**	149,084	43,352	332,558	524,994		524,994	(34,407)	490,587			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,399,229	276,534	697,791	2,373,554		2,373,554	(37,165)	2,336,389			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

** See schedule of adjustments attached at end of cost report.

Facility Name & ID Number Lynncrest Manor of Aledo #0041467 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7 **	8	9	10	
	D. Ownership											
30	Depreciation			94,322	94,322		94,322	354	94,676			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			234,067	234,067		234,067	2,397	236,464			32
33	Real Estate Taxes			17,210	17,210		17,210		17,210			33
34	Rent-Facility & Grounds							2,010	2,010			34
35	Rent-Equipment & Vehicles			6,929	6,929		6,929	708	7,637			35
36	Other (specify):*											36
37	**TOTAL Ownership**			352,528	352,528		352,528	5,469	357,997			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		24,766	4,016	28,782		28,782		28,782			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,900	54,900		54,900		54,900			42
43	Other (specify):* Nonallowable costs			101,221	101,221		101,221	(101,221)				43
44	**TOTAL Special Cost Centers**		24,766	160,137	184,903		184,903	(101,221)	83,682			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,399,229	301,300	1,210,456	2,910,985		2,910,985	(132,917)	2,778,068			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

**** See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lynncrest Manor of Aledo # 0041467 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,576)	2		4
5	Telephone, TV & Radio in Resident Rooms	(3,447)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(3)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,743)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(21,710)	43		18
19	Entertainment				19
20	Contributions	(565)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(937)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(66,043)	43		24
25	Fund Raising, Advertising and Promotional	(7,661)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(52)	43		28
29	Other-Attach Schedule See Schedule 5A	(1,735)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (105,472)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(27,445)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (27,445)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (132,917)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Lyncrest Manor of Aledo

ID# 0041467

Report Period Beginning: 01/01/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending machine income offset	$ (1,535)	2	1
2	Chamber of Commerce dues disallowed	(200)	20	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49				49
50				50
51				51
52				52
53				53
54				54
55				55
56				56
57				57
58				58
59				59
60				60
61				61
62				62
63				63
64				64
65				65
66				66
67				67
68				68
69				69
70				70
71				71
72				72
73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	(1,735)		90

Facility Name & ID Number Lynncrest Manor of Aledo # 0041467 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
DSI Partners, L.L.C	100.00%	Lynncrest Manor of Auburn	Auburn, Illinois	DSI Management		
(owned 55% by Jerry Neal, and		Lynncrest Manor of Effingham	Effingham, Illinois	Services, Inc.	Peoria, IL	Management Co.
15% each by Sherry Borum-Neal		Lynncrest Manor of Paris	Paris, Illinois	DSI Partners of		
Lester Robertson, and Ronald				Ohio, L.L.C	Peoria, IL	Management Co.
Mangum)						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Heat and Other Utilities	$	DSI Management Services, Inc.	A	$ 154	$ 154	1
2	V	6	Maintenance		DSI Management Services, Inc.	A	199	199	2
3	V	17	Management Fees	46,678	DSI Management Services, Inc.	A		(46,678)	3
4	V	19	Professional Services		DSI Management Services, Inc.	A	3,436	3,436	4
5	V	20	Fees, Subscriptions, & Promotions		DSI Management Services, Inc.	A	30	30	5
6	V	21	Clerical & General Office Exp.		DSI Management Services, Inc.	A	3,385	3,385	6
7	V	22	Employee Benefits		DSI Management Services, Inc.	A	4,189	4,189	7
8	V	23	Inservices Training & Education		DSI Management Services, Inc.	A	1,384	1,384	8
9	V	24	Travel & Seminar		DSI Management Services, Inc.	A	934	934	9
10	V	26	Insurance-Prop. Liab. Malpractice		DSI Management Services, Inc.	A	50	50	10
11	V	30	Depreciation		DSI Management Services, Inc.	A	354	354	11
12	V	32	Interest		DSI Management Services, Inc.	A	2,400	2,400	12
13	V	34	Rent-Facility and Grounds		DSI Management Services, Inc.	A	2,010	2,010	13
14	Total			$ 46,678			$ 18,525	$ * (28,153)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT A: Owned 100% by Jerry Neal

Facility Name & ID Number Lynncrest Manor of Aledo # 0041467 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	35	Rent-Equipment & Vehicles	$	DSI Management Services, Inc.	A	$ 708	$ 708	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 708	$ * 708	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT A: Owned 100% by Jerry Neal

Facility Name & ID Number Lynncrest Manor of Aledo # 0041467 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lynncrest Manor of Aledo # 0041467 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lynncrest Manor of Aledo # 0041467 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lynncrest Manor of Aledo # 0041467 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lynncrest Manor of Aledo # 0041467 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lynncrest Manor of Aledo # 0041467 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lynncrest Manor of Aledo # 0041467 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lynncrest Manor of Aledo # 0041467 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lynncrest Manor of Aledo # 0041467 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week Hours	Percent	Compensation Included in Costs for this Reporting Period** Description	Amount	Schedule V. Line & Column Reference	
1	Lester Robertson	Executive VP	Administrative	15.00%	74,461	6.69	17%	Salary	$ 14,982	L17, C1	1
2											2
3											3
4											4
5											5
6											6
7					See attached Schedule 7A						7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 14,982		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Lynncrest Manor of Aledo # 0041467 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DSI Management Services, Inc.
Street Address: 4239 War Memorial Drive
City / State / Zip Code: Peoria, IL 61614
Phone Number: (309) 685-0595
Fax Number: (309) 685-8463

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Heat and Other Utilities	Beds	597	8	$ 920	$	100	$ 154	1
2	6	Maintenance	Beds	597	8	1,187		100	199	2
3	19	Professional Services	Beds	597	8	20,515		100	3,436	3
4	20	Fees, Subscriptions, & Promotions	Beds	597	8	181		100	30	4
5	21	Clerical & General Office Exp.	Beds	597	8	20,209		100	3,385	5
6	22	Employee Benefits	Beds	597	8	25,009		100	4,189	6
7	23	Inservices Training & Education	Beds	597	8	8,260		100	1,384	7
8	24	Travel & Seminar	Beds	597	8	5,578		100	934	8
9	26	Insurance-Prop. Liab. Malpractic	Beds	597	8	298		100	50	9
10	30	Depreciation	Beds	597	8	2,116		100	354	10
11	32	Interest	Beds	597	8	14,327		100	2,400	11
12	34	Rent-Facility and Grounds	Beds	597	8	12,002		100	2,010	12
13	35	Rent-Equipment & Vehicles	Beds	597	8	4,225		100	708	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 114,827	$		$ 19,233	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lynncrest Manor of Aledo # 0041467 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Carol Fleming		x	Mortgage	$28,000.00	02/02/98	$ 2,500,000	$ 2,151,779	06/02/10	0.0900	$ 203,449	1
2	Carol Fleming		x	Building Improvement	$2,500.00	02/02/98	100,000	30,256	01/02/02	0.0900	9,063	2
3	NCS Lease		x	Hardware/Software	$297.00	10/31/98	17,833	11,373	09/30/03	0.1450	1,034	3
4												4
5												5
	Working Capital											
6												6
7												7
8								Provider Taxes			2,739	8
9	TOTAL Facility Related				$30,797.00		$ 2,617,833	$ 2,193,408			$ 216,285	9
	B. Non-Facility Related*											
10								Allocated from DSI Partners, L.L.C.			12,510	10
11								Allocated from Management Company			2,400	11
12								Miscellaneous Interest			5,272	12
13								Interest Income Offset			(3)	13
14	TOTAL Non-Facility Related						$	$			$ 20,179	14
15	TOTALS (line 9+line14)						$ 2,617,833	$ 2,193,408			$ 236,464	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Lynncrest Manor of Aledo # 0041467 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.		$ 16,262	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	1999	$ 16,736	2
3. Under or (over) accrual (line 2 minus line 1).		$ 474	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 16,736	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 17,210	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1995		8
1996	16,187	9
1997	15,598	10
1998	16,262	11
1999	16,736	12

Real estate tax accrual is based on 100% of prior year's tax bill.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Lynncrest Manor of Aledo # 0041467 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 27,378 B. General Construction Type: Exterior Brick Frame Block Number of Stories 1

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [x] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A

3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Patient Care	103,498	1998	$ 40,750	1
2					2
3	TOTALS	103,498		$ 40,750	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lynncrest Manor of Aledo # 0041467 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	100		1998	1973, 1975	$ 2,279,250	$ 56,981	40	$ 56,981	$	$ 161,447	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Sign			1996	1,391	93	10	93		424	9
10	6 air conditioners			1996	4,071	407	10	407		1,822	10
11	2 air conditioners			1997	1,139	113	10	113		411	11
12	Boiler			1997	3,620	241	15	241		924	12
13	Alzheimer's Wing			1998	64,445	4,301	15	4,301		11,633	13
14	Fire Alarm, Wiring			1999	772	51	15	51		81	14
15	Providence Wing Remodeling			1999	18,509	1,234	15	1,234		1,851	15
16	Air conditioner Sleeve			1999	1,880	187	10	187		317	16
17	Water Heater			1999	696	69	10	69		75	17
18	Security Locks			2000	4,513	301	15	301		301	18
19	Water Heater			2000	500	29	10	29		29	19
20	Air conditioner Sleeve			2000	2,753	119	10	119		119	20
21	Door Alarm			2000	1,138	27	10	27		27	21
22	Nurses Call Station			2000	5,277	484	10	484		484	22
23	Electrical Wiring on A/C			2000	669	11	10	11		11	23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 2,390,623	$ 64,648		$ 64,648	$	$ 179,956	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lynncrest Manor of Aledo # 0041467 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 275,873	$ 28,522	$ 28,522	$	10	$ 75,495	37
38	Current Year Purchases	1,850	175	175		10	175	38
39	Fully Depreciated Assets							39
40	Allocated from Management Company			354	354			40
41	TOTALS	$ 277,723	$ 28,697	$ 29,051	$ 354		$ 75,670	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Resident Care	Van	1996	$ 9,768	$ 977	$ 977	$	10	$ 4,640	42
43										43
44										44
45										45
46	TOTALS			$ 9,768	$ 977	$ 977	$		$ 4,640	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 2,718,864	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 94,322	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 94,676	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 354	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 260,266	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: n/a

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6	Allocated from Management Company				2,010			6
7	TOTAL				$ 2,010 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 1,937 Description: Postage Meter-$579; Dishwasher-$650; Allocated from Management Company $708
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Patient Care	1992 Buick Roadmaster	$ 475.00	$ 5,700	17
18					18
19					19
20					20
21	TOTAL		$ 475.00	$ 5,700	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Lynncrest Manor of Aledo # 0041467 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [x] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [x]
- HOURS PER AIDE 8

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$ 5,756	$	$ 5,756
2	Books and Supplies				
3	Classroom Wages (a)		7,906		7,906
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$ 13,662	$	$ 13,662
10	SUM OF line 9, col. 1 and 2 (e)	$ 13,662			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	9
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	9

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4		5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L10a, C3	hrs	$	1,466	$	75,668	$	1,466	$ 75,668	1
2	Licensed Speech and Language Development Therapist	L10a, C3	hrs		83		9,444		83	9,444	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	L10a, C3	hrs		672		31,485		672	31,485	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	L39, C2	# of prescrpts					24,766		24,766	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify): See Schedule 16A						4,016			4,016	13
14	TOTAL			$	2,221	$	120,613	$ 24,766	2,221	$ 145,379	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Lynncrest Manor of Aledo
Provider #0041467
12/31/2000

Schedule 16A

XIV. Special Services
Line 13 Other (specify):

Service	Line Reference	Outside Practioner Units	Cost	Supplies
X-ray	L39, C3		60	
Laboratory	L39, C3		3,558	
Special Services	L39, C3		310	
Urological	L39, C3		88	
Total			4,016	0

See Accountants' Compilation Report

Facility Name & ID Number Lynncrest Manor of Aledo **#** 0041467 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/00 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 26,799	$ 26,799	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 78,513)	271,189	271,189	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	65,432	65,432	6
7	Other Prepaid Expenses	19,158	19,158	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due From Related Parties	24,038	24,038	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 406,616	$ 406,616	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	40,750	40,750	13
14	Buildings, at Historical Cost	2,279,250	2,279,250	14
15	Leasehold Improvements, at Historical Cost	98,460	111,373	15
16	Equipment, at Historical Cost	300,404	287,491	16
17	Accumulated Depreciation (book methods)	(260,266)	(260,266)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,458,598	$ 2,458,598	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,865,214	$ 2,865,214	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 357,784	$ 357,784	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	79,296	79,296	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,033	7,033	31
32	Accrued Real Estate Taxes(Sch.IX-B)	16,736	16,736	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	691,938	691,938	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,152,787	$ 1,152,787	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	11,373	11,373	39
40	Mortgage Payable	2,182,035	2,182,035	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Schedule 17A	1,730,311	1,730,311	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,923,719	$ 3,923,719	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,076,506	$ 5,076,506	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,211,292)	$ (2,211,292)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,865,214	$ 2,865,214	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Lynncrest Manor of Aledo
Provider #0041467
12/31/2000

Schedule 17A

XV. Balance Sheet
Other Current Liabilities-Line 36

	Operating	After Consolidating
Due to Auburn	401,971	401,971
Due to Effingham	43,863	43,863
Accrued Participation Fees	13,800	13,800
Trustmark Payable	72	72
Due to Credit Union Payable	1,129	1,129
Due to DSI Management	24,600	24,600
L/P Jerry Neal	183,800	183,800
Due to NHM #5	8,000	8,000
Due to IDPA	10,872	10,872
Leases Payable-Partners Leasing, Inc.	3,831	3,831
Total Other Current Liabilities	**691,938**	**691,938**

XV. Balance Sheet
Other Long-Term Liabilities-Line 43

Due to DSI Partners, LLC	1,697,311	1,697,311
Due to DSI Partners of Ohio	33,000	33,000
Total Other Long-Term Liabilities	**1,730,311**	**1,730,311**

See Accountants' Compilation Report

Facility Name & ID Number Lynncrest Manor of Aledo # 0041467 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,626,499)	1
2	Restatements (describe):		2
3	**Prior Period Adjustments**	(28,943)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,655,442)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(555,850)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (555,850)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (2,211,292)	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lynncrest Manor of Aledo # 0041467 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,240,548	1
2	Discounts and Allowances for all Levels	(189,458)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,051,090	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	247,192	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 247,192	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,576	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	37,235	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	5,143	19
20	Radiology and X-Ray		20
21	Other Medical Services	9,375	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 53,329	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending machine income	1,535	28
28a	Miscellaneous income	1,986	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,521	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,355,135	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	538,428	31
32	Health Care	1,310,132	32
33	General Administration	524,994	33
	B. Capital Expense		
34	Ownership	352,528	34
	C. Ancillary Expense		
35	Special Cost Centers	130,003	35
36	Provider Participation Fee	54,900	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,910,985	40
41	**Income before Income Taxes (line 30 minus line 40)****	(555,850)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (555,850)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** No **If not, please attach a reconciliation.**
This entity files as part of a combined cash basis return.

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Lynncrest Manor of Aledo # 0041467 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,049	2,049	$ 37,350	$ 18.23	1
2	Assistant Director of Nursing	149	149	2,255	15.13	2
3	Registered Nurses	6,650	7,124	120,137	16.86	3
4	Licensed Practical Nurses	11,000	11,629	158,151	13.60	4
5	Nurse Aides & Orderlies	50,840	53,175	429,420	8.08	5
6	Nurse Aide Trainees	1,378	1,378	7,906	5.74	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	669	722	6,605	9.15	8
9	Activity Director	5,308	5,551	34,394	6.20	9
10	Activity Assistants					10
11	Social Service Workers	2,276	2,325	20,172	8.68	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,814	17,391	115,464	6.64	15
16	Dishwashers					16
17	Maintenance Workers	1,874	1,898	20,295	10.69	17
18	Housekeepers	10,289	10,899	68,557	6.29	18
19	Laundry	3,887	4,060	22,410	5.52	19
20	Administrator	2,509	2,925	50,316	17.20	20
21	Assistant Administrator					21
22	Other Administrative	335	348	14,982	43.05	22
23	Office Manager					23
24	Clerical	6,535	6,825	83,786	12.28	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,047	2,271	16,481	7.26	31
32	Other Health Care: See Schedule 20A	19,988	20,546	190,548	9.27	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	144,597	151,265	$ 1,399,229 *	$ 9.25	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	306	$ 12,856	L1, C3	35
36	Medical Director	Monthly	6,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	164	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	37	1,949	L11, C3	44
45	Social Service Consultant	44	2,293	L12, C3	45
46	Other(specify)				46
47	Active Treatment Consultant	45	2,982	L11, C3	47
48	Office Consultant	24	1,922	L21, C3	48
49	TOTAL (lines 35 - 48)	456	$ 28,166		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	123	$ 4,016	L10, C3	50
51	Licensed Practical Nurses	1,365	38,332	L10, C3	51
52	Nurse Aides	2,803	50,712	L10, C3	52
53	TOTAL (lines 50 - 52)	4,291	$ 93,060		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Lynncrest Manor of Aledo
Provider #0041467
12/31/2000

Schedule 20A

XVIII. Staffing and Salary Costs
Other (specify) - Line 33

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Alzheimer Director	1,748	1,820	18,201	10.00
MDS Reviewer	207	227	3,296	14.52
HAB Techs	16,265	16,683	143,195	8.58
Ancillary Clerk	129	129	942	7.30
Care Plan Coordinator	1,639	1,687	24,914	14.77
Total	19,988	20,546	190,548	

See Accountants' Compilation Report

Facility Name & ID Number Lynncrest Manor of Aledo # 0041467 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
William Willet	Administrator	0.00%	$ 50,316
Lester Robertson	Exec, Vice Pres.	15.00%	14,982
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 65,298

B. Administrative - Other

Description	Amount
Management Fees (eliminated in column 7)	$ 46,678
TOTAL (agree to Schedule V, line 17, col. 3)	$ 46,678
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Altschuler, Melvoin & Glasser LLP	Accounting	$ 8,071
Personnel Planners	U/C Consulting	834
ADP	Payroll Service	5,914
AHCA	Computer Services	850
Therapeak	Computer Services	710
NCS	Computer Services	2,845
Miscellaneous Computer Services		3,605
Mangum, Smietanka & Johnson L.L.C.	Legal	7,781
American Express Tax & Bus. Serv.	Accounting	959
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 31,569

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 29,155
Unemployment Compensation Insurance	21,017
FICA Taxes	101,981
Employee Health Insurance	15,534
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	504
Other Employee Benefits	8,505
Allocated from Management Company	4,189
TOTAL (agree to Schedule V, line 22, col.8)	$ 180,885

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
n/a		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	3,589
Health Care Worker Background Check	
(Indicate # of checks performed 139)	973
Illinois Health Care Association	4,080
Miscellaneous License & Subscriptions	342
Miscellaneous Dues	243
MES Group Purchasing	36
Allocated from Management Company	30
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 9,493

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	231
Seminar Expense	7,037
Allocated from Management Company	934
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,202

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lynncrest Manor of Aledo # 0041467 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2	n/a												
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lynncrest Manor of Aledo # 0041467 Report Period Beginning: 01/01/00 Ending: 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Association-$4,080**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **n/a**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **3,086** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **n/a**

(9) Are you presently operating under a sublease agreement? YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **54,900**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **1,576**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **n/a**
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **Adequate records are maintained**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **n/a**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **n/a** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **n/a** If no, please explain. **n/a**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.